

Monitoring to prevent coding errors

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The government is continually monitoring claims for coding errors. The best way to prevent the government from finding your errors is to continually monitor the accuracy of coding activities.

There are many reasons for an inaccurate code. The most common reason is when your medical record documentation does not support the billed code. Other reasons include:

- data input errors
- misunderstandings about which code to use for a given clinical situation
- when a coder misinterprets a clinician's notation

Inaccurate coding can also be traced to the use of non-credentialed coders. Many do not use nationally recognized coding guidelines to conduct cost effective monitoring programs.

To remedy this, compliance officers should ensure that health information managers (HIM) monitor coding assignments, and compare the codes to the medical records. This inquiry should include a review of the overpayment letters that occurred as a result of inaccurately billed codes.

The internal coding staff should be the primary group conducting this coding activity. But bring in coding experts occasionally to audit the overall operation. Use these external audit results to identify weaknesses in the overall operation, to find better ways to monitor the coding process, and to take advantage of the best practices these auditors bring to the audit.

A coder can be more successful if given every opportunity to work with others in the organization. The relationship between billing and coding is an especially important component of a successful coding monitoring operation. HIM managers should work with the compliance department to ensure that other players are educated about how their work can affect a coder's job.

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